BIRMINGHAM ALLERGY & ASTHMA SPECIALISTS, PC $\underline{\textbf{HISTORY \& PHYSICAL}}$

NAME:	TO BE COMPLETED BY PHYSICIAN
APPOINTMENT DATE:	
DATE OF BIRTH:	CHIEF COMPLAINT:
PRIMARY CARE PHYSICIAN:	
REFERRED BY:	
TO BE COMPLETED BY PATIENT	
Please describe in your own words the reason for this visit.	
	HISTORY OF PRESENT ILLNESS:
CURRENT MEDICATIONS: Please list all medications, both prescribed by a physician and obtained without a prescription (over the counter), that you are currently taking.	

ASSOCIATED SYMPTOMS: Nasal lichy Runny Congested Sneezing Snoring Mouthbreather Nosebleeds Medical History: 1. Have you ever had nasal or sinus surgery? 2. Have you had a tonsillectomy or adenoidectomy? 3. Have you had a tonsillectomy or adenoidectomy? 4. Have you ever been tested for allergy? 5. Have you had ear tubes? 6. List all drug allergies: ASSOCIATED SYMPTOMS: Nasal lichy Runny Congested Sneezing Snoring Mouthbreather Nosebleeds Nosebleeds Nosebleeds Nasal litchy Runny Congested Sneezing Mouthbreather Nosebleeds Nosebleeds Nosebleeds Nosebleeds Nation: Headache Pressure Infections Fact: Itchy Popping OM Hearing Loss Fyee: Itchy Runny Swelling Redness Strop Clearing Chest: Cough Wheeze Tightness SOB Skin: Itchy Hives Eczema Itchy Pala are tubes Eczema Palate: Itchy Hives Eczema Itchy Hives Eczema Itchy PhD Hoarseness Strep Clearing Chest: Cough Wheeze Tightness SOB Skin: Itchy Hives Eczema Shadyr: Steroids/yr: Family History Mother Father Sibling Other Rhimitis: Sibling Ot	NAME:	TO RE COM	IDI ETEN I	ev dhvei	CIAN		
Nasal Itchy Runny Congested Sneezing Snoring Mouthbreather Nosebleeds Sneezing Mouthbreather Nosebleeds Sneezing Mouthbreather Nosebleeds Sneezing Mouthbreather Nosebleeds Sinus: Headache Pressure Infections Itchy Popping OM Hearing Loss Lichy Runny Swelling Redness Type: Itchy Runny Swelling Redness Type: Throat: Itchy PND Hoarseness Strep Clearing Date(s): Chest: Cough Wheeze Tighness SOB Stin: Itchy Palate: Itchy Hoarseness Strep Clearing Date(s): Sini: Itchy Hives Eczema Eczema Falate: Itchy		ASSOCIATED SYMPTOMS.					
Sinus: Headache Pressure Infections	AFFOINTMENT DATE.				Congested	Sneezing	
Medical History: Infections Ear: Itchy Popping OM Hearing Loss Eye: Itchy Rumny Swelling Redness Type: Throat: Itchy PND Hoarseness Strep Clearing Date(s): Chest: Cough Wheeze Tightness SOB Skin: Itchy PND Hoarseness Strep Clearing Chest: Cough Wheeze Tightness SOB Skin: Itchy Hives Eezema Family History Family	TO RE COMPLETED BY PATIENT	Ivasai	•	•	_		
I. Have you ever had nasal or sinus surgery? [] Yes [] No Type: Date(s): Chest: Cough Wheeze Tightness SOB Skin: Itchy Hives Eczema [] Yes [] No Date(s): Abv/yr: [] Yes [] No Date(s): Have you had a tonsillectomy or adenoidectomy? [] Yes [] No Date(s): Have you had ear tubes? [] Yes [] No Date(s): Have you ever been tested for allergy? [] Yes [] No Date(s): Have you ever had allergy injections [] Yes [] No If so, please give dates: Did they help? E. List all drug allergies: Kear: Itchy Popping OM Hearing Loss Face: Itchy Runny Swelling Redness Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Clearing Redness Strep: Clearing Redness Strep: Clearing Redness Strep: Litchy PND Hoarsenss Strep Clearing Redness Strep: Clearing Redness Strep: Clearing Redness Face: Itchy PND Hoarsenss Strep Clearing Redness Strep: Clearing Redness Strep: Clearing Redness Filtchy PND Hoarsenss Strep Clearing Redness Strep: Clearing Redness Face: Itchy PND Hoarsenss Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Clearing Redness Strep: Clearing Redness Face: Itchy PND Hoarsenss Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Tightness Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Tightness Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Tightness Strep Tightness Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Tightness Strep Tightness Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Tightness Strep Tightness Strep Tightness Strep Clearing Redness Face: Itchy PND Hoarsenss Strep Tightness Strep Tightness Strep Tightness Strep Tightness Strep Clearing Redness Face: Itchy Redness Face: Itchy Hives Eczema Hitchy Rhinitis: Itchy Mother Father Sibling Cherical Strep Tightness Strep Tightness Strep Tightness Strep Clearing Redness Face: Itchy Howes Tightness Strep Tightne		Sinus	Ü				
Eye: Itchy Runny Swelling Redness Type: Date(s): Chest: Cough Wheeze Tightness SOB Skin: Itchy Hives Eezema Palate: Itchy Date(s): Have you had a tonsillectomy or adenoidectomy? [] Yes [] No Date(s): Have you had ear tubes? [] Yes [] No Date(s): Have you ever been tested for allergy? [] Yes [] No If so, did you have skin tests/ RAST (blood) tests? [] Yes [] No If so, please give dates: Did they help? List all drug allergies: Khave you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No Khave you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No Children:							
Type: Date(s): 2. Have you had a tonsillectomy or adenoidectomy? [] Yes [] No Date(s): 3. Have you had ear tubes? [] Yes [] No Date(s): 4. Have you ever been tested for allergy? [] Yes [] No If so, did you have skin tests/ RAST (blood) tests? [] Yes [] No Shawe you ever had allergy injections [] Yes [] No If so, please give dates: Did they help? 6. List all drug allergies: Throat: Itchy PND Hoarseness Strep Clearing Chest: Cough Wheeze Tightness SOB Skin: Itchy Hives Eczema Hives Habet: Itchy Mother Father Sibling Other Rhinitis:			•			C	
Date(s): 2. Have you had a tonsillectomy or adenoidectomy? [] Yes [] No Date(s): 3. Have you had ear tubes? [] Yes [] No Date(s): 4. Have you ever been tested for allergy? [] Yes [] No If so, did you have skin tests/ RAST (blood) tests? [] Yes [] No Stemids/yr: Mother Father Sibling Other			•	•	·		
2. Have you had a tonsillectomy or adenoidectomy? [] Yes [] No Date(s): 3. Have you had ear tubes? [] Yes [] No Date(s): 4. Have you ever been tested for allergy? [] Yes [] No If so, did you have skin tests/ RAST (blood) tests? [] Yes [] No If so, please give dates: Did they help? 6. List all drug allergies: 8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No Children:	•		-			_	
[] Yes [] No Date(s): 3. Have you had ear tubes?			•		C		
Date(s): 3. Have you had ear tubes? [] Yes [] No Date(s): 4. Have you ever been tested for allergy? [] Yes [] No If so, did you have skin tests/ RAST (blood) tests? [] Yes [] No Steroids/yr: Mother Father Sibling Other			•				
Abx/yr:		Infections/yr	•				
Date(s): 4. Have you ever been tested for allergy? [] Yes [] No If so, did you have skin tests/ RAST (blood) tests? [] Yes [] No 5. Have you ever had allergy injections [] Yes [] No If so, please give dates: Did they help? 6. List all drug allergies: 7. List all food allergies: Simily History Mother Father Sibling Other	3. Have you had ear tubes?						
4. Have you ever been tested for allergy? [] Yes [] No If so, did you have skin tests/ RAST (blood) tests? [] Yes [] No Asthma: [] Yes [] No Hives: [] Yes [] No If so, please give dates: Did they help? 6. List all drug allergies: 7. List all food allergies: 8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No Children:	[] Yes	Steroids/yr:					
[] Yes [] No If so, did you have skin tests/ RAST (blood) tests? [] Yes [] No Asthma:	Date(s):	Family Histo	or <u>y</u>				
[] Yes [] No If so, did you have skin tests/ RAST (blood) tests? [] Yes [] No Asthma:	4. Have you ever been tested for allergy?		Mother	Father	Sibling	Other	
[] Yes [] No Asthma: Hives: [] Yes [] No Eczema: Migraines: Did they help? 6. List all drug allergies: The standard and a severe reaction to a bee sting or an ant bite? [] Yes [] No Asthma: Hives: Eczema: Migraines: Siblings: Children: Children:	[] Yes [] No	Rhinitis:					
5. Have you ever had allergy injections [] Yes [] No If so, please give dates: Did they help? 6. List all drug allergies: 7. List all food allergies: 8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No Hives: Children:	If so, did you have skin tests/ RAST (blood) tests?	Sinus:					
[] Yes [] No If so, please give dates: Did they help? 6. List all drug allergies: The so, please give dates: Did they help? Rheum: Immunodef: Siblings: Children: 8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No	[] Yes	Asthma:					
If so, please give dates: Did they help? 6. List all drug allergies: Thumunodef: Siblings: Children: 8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No	5. Have you ever had allergy injections	Hives:					
Did they help? 6. List all drug allergies: Immunodef:	[] Yes [] No	Eczema:					
6. List all drug allergies: Siblings:	If so, please give dates:	Migraines:					
7. List all food allergies: Children: 8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No	Did they help?	Rheum:					
7. List all food allergies: Children: 8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No	•	Immunodef:					
7. List all food allergies: 8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No Children:							
7. List all food allergies: 8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No Children:		Siblings:					
8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No							
8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No	7. List all food allergies:						
8. Have you ever had a severe reaction to a bee sting or an ant bite? [] Yes [] No							
an ant bite? [] Yes [] No		Children:					
[] Yes [] No	8. Have you ever had a severe reaction to a bee sting or						
	an ant bite?						
	Describe:						

NAME:					IO BE COMPLE	<u>IED BY PHYSICIAN</u>	
APPOINTMENT DATE:				PHYSICAL EXAM:			
TO BE COMPLETED BY PATIENT				WT:	HT: P: BP:		
Check the following medical conditions that		T:	P: BP:				
you have currently or hav	<u>e had</u> Curi		ne pa Pa		GENERAL APPEAR	RANCE:	
Eye Disease	[]	[]	EYES:	Conjuntiva – Normal R L; Red R L	
Nasal Polyps	[]	[]		Lids – Normal R L; Edema R L	
Emphysema	[]	[]		Shiners Dennie's Lines	
Croup	[]	[]	EARS:	TMS – Normal R L; Dull R L; Red R L	
Heart Disease	[]	[]		Canals - Normal Occluded	
Mitral Valve Prolapse	[]	[]	NOSE:	Nasal Crease	
Gastroesophageal Reflux	[]	[]		Mucosa - Normal Pale Red	
Ulcers	[]	[]		Edema – R - Mild Moderate Severe	
Colitis or Diverticulitis	[]	[]		L - Mild Moderate Severe	
Bladder Infections	[]	[]		Mucous – Mild Moderate Copious	
Prostate Problems	[]	[]		Mucoid Serous	
Arthritis	[]	[]		Polyps - None; Present R L	
Migraines	[]	[]		Septum – Midline; Deviated R L	
Seizures	[]	[]		Perforated Excoriated R L	
Depression	[]	[]	ORPHARYNX:	Palate – Normal Other:	
Anxiety	[]	[]		Post Pharynx - Normal Injected	
High Blood Pressure	[]	[]		Cobblestoned PND	
Diabetes	[]	[]	TEETH & GUMS:	Normal Other:	
Thyroid Disease	[]	[]	FACE/SINUS TEND	ERNESS: Absent Frontal Maxillary	
Cancer	[]	[]	NECK:	Normal Appearance	
Other:	[]	[]	THYROID:	Normal Enlarged	
	[]	[]	LYMPHATICS:	Neck Axilla Groin	
	[]	[]	CHEST:	Ventilation - Normal Retractions	
					PRE	Auscultation - Normal	
Please list all hospitalizations (including year & reason)			Wheezes R L Bilat				
1.						Rhonchi R L Bilat	
2.					POST	Auscultation - Normal	
3.						Wheezes R L Bilat	
4.						Rhonchi R L Bilat	

NAME:	TO BE COMPLETED BY PHYSICIAN
APPOINTMENT DATE:	
TO BE COMPLETED BY PATIENT	Physical Exam (continued):
For children under 15, complete the following: 1. Birth Weight: 2. Were there any complications following delivery?	CVS: Heart- PV (observ/palp)-
[] Yes [] No Explain:	ABDOMEN: Tenderness Mass Liver/Spleen – Normal Enlarged
3. Has growth and development been normal? [] Yes [] No Explain:	EXTREMITIES:
4. Are immunizations up to date? [] Yes [] No	SKIN: Normal Lichenified Excoriated Oozing Erythema Wheals Papules Dermatographic
Social History: Current Occupation:	
(if applicable): Mother's Occupation: Father's Occupation:	
Marital Status: []Single []Married []Divorced []Widowed []Significant Other []Life Partner	NEURO/PSYCH: Orientation - Mood/Affect - OTHER:
Smoking History:	OTHER.
[]Current []Past Started/How long	NOTES:
Environmental History: (Please check the appropriate boxes)	
Home: []House []Apartment []Condo	
[]Indoors by []Outdoors by	
Heat: []Central []Radiator	
Air conditioning: []Central []Window	
Pillows: []Feather []Non-feather Age:	
Bed: []Mattress/Boxspring []Waterbed	
[]Bunkbed Top Bunk Bottom Bunk	
Age:	
Flooring: []Hardwood []Carpet Age:	
Basement or Crawlspace:	
[]Dry []Damp []Musty	